Guidelines, Page 1-2

I. OBJECTIVES

The State of Wisconsin Group Insurance Board intends these "Terms for Comprehensive Medical Plan Uniform Benefits and Contract with Group Insurance Board to Participate under the State of Wisconsin Group Health Benefit Program" (hereinafter referred to as "Guidelines") to accomplish the goals and objective stated below. Use of the term "Guidelines" is an historical anachronism and does not imply that the benefits and agreements stated herein are advisory rather than binding terms. Further, all parties contracting with the Group Insurance Board agree that these terms shall always be interpreted consistent with the objectives stated herein.

The Board's objective with alternate health care programming is: to encourage the growth of alternate health benefit plans which are able to deliver health care benefits in an efficient and economical fashion and to limit and discourage the growth of plans which do not; to provide employees the opportunity to choose from more than one comprehensive health benefit plan.

By statute, the Group Insurance Board (Board) has the authority to negotiate the scope and content of the group health insurance program(s) for employees and retired employees of the State of Wisconsin, as well as local units of government.

Local governments seeking to participate in the health insurance program must meet a 65% level of participation unless they are a small employer as defined under Wis. Stats. §635.02 (7). Local governments that are small employers must meet a participation level in accordance with Wis. Adm. Code § INS 8.46 (2) to participate. Eligible employees who have other qualifying health insurance coverage are excluded when calculating the participation level. This participation requirement may be waived by ETF on a case-by-case basis for employers for whom the timing of collective bargaining agreements prevents the minimum participation level at any given time.

The Board is committed to the concept of providing employees with comprehensive health benefit programs and ensuring that such benefits are delivered in an efficient and economical manner. The intent is to provide employees with the opportunity to be covered by health benefit program(s), which will provide benefits, and services, which are substantially similar to those provided under the standard, fee-for-service, group health insurance program. Therefore, the Board has developed these Guidelines by which alternate health delivery plans may be evaluated for possible inclusion under the State of Wisconsin's group health benefit program on a "dual-choice" basis.

"Dual-choice" refers to a program where employees (including retirees and continuants) who are currently insured have the opportunity to choose between at least two competing health benefit plans, the standard plan and one or more alternate plans. The mechanics of "dual-choice" are relatively simple. Once an alternate plan receives approval from the Board on the benefit structure, its proposed premium rate is submitted as a sealed bid. The bid will be reviewed for reasonableness, considering plan utilization, experience and other relevant factors. Bids are subject to negotiation by the Board. The Board reserves the right to reject any proposal, which fails to include adequate documentation on the development of premium rates. These Guidelines provide a detailed explanation of the required documentation.

The current program requires alternate health care plans to submit their premium rate quotations for the following calendar year. The Board reserves the right to change to a fiscal year or to some other schedule that it deems appropriate.

preceding contract period) shall constitute sufficient grounds for the Board to deny future renewals, or consider the plan to be non-qualifying.

D. Comprehensive Health Benefit Plans Eligible for Consideration

1. The Board will only consider those plans, which provide benefit payments, or services which are, in whole or substantial part, delivered on a prepaid basis or which meet the requirement for preferred provider plans. The Board reserves the right not to contract with any plan whose premium is not satisfactory to the Board.

2. Plans that will be considered under these program guidelines to be allowed in any service area include any of the following types of Organizations defined in Wis. Stats. § 609.01 (2) and (4):

   a. Independent practice association HMO (IPA's).

   b. Prepaid group practice HMO.

   c. Staff model HMO.

   Plans that will be considered under these guidelines to be offered in any county also include:

   a. Point of service HMOs (POS-HMO).

   b. Preferred Provider Plan (PPP).

   Plans that embrace the characteristics of one or more of the type of organization models described above may be considered by the Group Insurance Board as meeting the definition of a comprehensive health benefit plan. Insuring organizations may not offer more than one of the above listed plan types in any geographic location. This allows organizations sufficient flexibility to develop innovative alternative plans while recognizing the Board's need for administrative efficiency and protection of the competitive environment.

3. Plans must provide for the Wisconsin State Employees' Program benefits and services listed in Section 4. For Wisconsin Public Employers, a plan may use the same addendum or maintain benefit levels identical to the 1993 coverage year.

4. Plans must demonstrate their efforts in encouraging and/or requiring network hospitals to participate in such quality standards as Leapfrog and others as identified by the Department.

5. Plans must demonstrate effective and appropriate means of monitoring and directing patient's care by participating physicians. (Utilization Review; UR) Each plan shall report to the Board its capabilities and effectiveness.

   Examples of the minimum UR procedures that participating alternate plans should have in place include the following:

   - Members are required to select primary care physicians who coordinate the member's care in the plan's network and approve referrals to specialists.

   - Written guidelines that physicians must follow to comply with the plan's UR program for IPA model HMOs.

A. Capital Equipment and Expenditures.

Each applicant must provide in its proposal a detailed explanation of how capital equipment and expenditures for the facility are authorized. If your organization is not specifically providing services but rather, functioning as a sponsor, include within your proposal the following statement:

> "Item F. of the Guidelines is not applicable to this organization. The purchase of capital equipment, etc., is not subject to review by either the state or federal health agencies."

If the approval of capital equipment and expenditures is subject to review by state and/or federal agencies, the applicant should provide information on the organization(s) involved in general reporting requirements. One such example would be Section 1122, Public Law 92-603.

B. Enrollment and Reporting.

If an organization submits a proposal to participate under the State of Wisconsin's group health benefit program and the proposal receives approval by the Board, the plan will be offered to active and retired public employees at a time established by the Board (dual-choice enrollment) subject to the following:

1. Any plan, which receives approval from the Group Insurance Board, must:

   a. Secure a minimum of 100 subscriber contracts (state/local employees enrolled; this number does not include any dependents covered under the plan) or;

   b. Demonstrate that 10% of the eligible employees within the area to be serviced by the plan have opted to participate in the program.

2. The Board may waive the minimum participation requirement set forth under Section II., G., 1., provided the organization submits a marketing plan which demonstrates that this minimum number of contracts will be obtained at some future date. The marketing proposal should include some evidence that the benefit plan has been accepted to a similar extent by employees of other groups and the location is convenient to potential subscribers. This marketing plan will be considered confidential by the Board insofar as permitted by Wisconsin Law.

   As stated previously, each plan so approved will be required to offer annually, a "dual-choice enrollment" opportunity. The Board establishes when such dual-choice enrollment periods will be held. Each plan will be required to prepare informational materials in a form and content acceptable to the Board.

3. Each organization must demonstrate to the Board's satisfaction its ability to provide the following:

   a. The specified level of services to enrollees.

   b. An adequate mechanism for maintaining records on each enrolled employee and covered dependents, including but not limited to, initial determination of eligibility for dependents for handicapped and full-time student status.

   c. Effective methods for containing costs for medical services, hospital confinements or any other benefit to be provided. Particular emphasis should be placed on the presence of an effective peer review mechanism and utilization review mechanism for monitoring health care costs. The Board is also particularly interested in COB (Coordination of Benefit) provisions such as third party requests, dual-coverage under different plans, etc.

f) Take no action.

3) The Board requires the information concerning any change in ownership or controlling interest, any merger or any acquisition of another participating plan in order to fulfill the Board's responsibility to assess the effects of the pending action upon the best interests of the group health insurance program and insured employees. The Board pledges to keep the information disclosed as required under par. (b) temporarily confidential unless the plan waives confidentiality or a court orders the Department or Board to disclose the information or the Department or Board determines that under the particular circumstances, any harm to the public interest that would result from permitting inspection is outweighed by the public interest in immediate inspection of the records. The Board also agrees to notify the plan of a request to disclose the information as a public record prior to making such disclosure, so as to permit the plan to defend the confidentiality of the information. Information disclosed by a plan concerning any change in ownership or controlling interest, any merger or any acquisition of another participating plan will be treated as a public record beginning on the earliest of the following dates:

a) The date the pending change in ownership or controlling interest, any merger or any acquisition of another participating plan becomes public knowledge, as evidenced by public discussion of the action including but not limited to newspaper accounts.

b) The date such action becomes effective.

c) 60 days after the Board receives the information.

4) The Board shall reserve the right to institute action as it deems necessary to protect the interests of its employees and dependents, as the result of a "significant event."

l. Agree to assign ID numbers (Group and subscriber) according to the system established by the Department of Employee Trust Funds. It is preferable but not mandatory to assign ID numbers that are not correlated to social security numbers. However, upon member request, such an ID number must be assigned. Social Security numbers may be incorporated into the subscriber's data file and may be used for identification purposes only and not disclosed or used for any other purpose. Plans must always keep record of social security numbers for providing data and other reports to the Department of Employee Trust Funds.

m. Upon request of the Department or the participant, the plan must provide the total dollar amount of claims paid by the plan that has been applied towards the participant’s lifetime benefit maximum.

n. The plan’s provider network must comply with the access standards set forth in WI Adm. Code INS § 9.34.

o. Provide coverage for eligible children as required under the National Medical Support Notice, a State and Federal law providing for a special enrollment opportunity for eligible children in certain cases when ordered by a court.

3. Graduate Assistants[1]: Individual rate must be within a range of 65% to 75% of the individual regular coverage rate; family rate must be within a range of 65% to 75% of the family regular coverage rate.

4. The Board will consider rate proposals outside of these standards if the variation is supported by evidence of genuine demographic differences other than age or sex, or is required by federal or state HMO regulations to be community-rated. Otherwise, aberrations will be adjusted by the Board upward or downward to the nearest within range percentage to conform with these Guidelines. The plan will then have the option of accepting the adjusted rates or withdrawing from the program.

5. The Board will assess administration fees to cover expenses of the Department of Employee Trust Funds. This charge is added by the Board to the rates quoted by each alternate plan and is collected prior to transmittal of the premiums to the alternate plans.

6. Include completed Table contained in Addendum #1A.

I. Submission of Proposals

Proposals to participate in the state group health insurance program must be submitted to the Board. In addition to requirements previously cited, each plan proposal must be received by May 15 and include:

1. Fifteen (15) copies

2. Specific listing of the plan's pre-authorization and referral requirements

3. A draft of the contract to be executed between the Plan and the Board (see Addendum #3). Premium quotations, however, are not due until July 30.

4. A list of providers under contract arranged by county of practice for state employees, and by zip code for local employees. The Board will expect an updated listing by July 30 in order to determine what areas will constitute your service area for the determination of employer contribution toward premium.

5. A copy of your detailed contingency plan in the event of strike, disaster, etc. Such a plan must address the method used for providing services and processing claims under such circumstances.

The Board will treat all proposals as confidential insofar as is permitted by applicable law, except as may be necessary for the proper evaluation of the proposal.

[1] Graduate Assistants ~~and employes in training at the University of Wisconsin are covered~~ by Wis. Stats. § 40.52 (3), Employes who are employed at least one-third of full-time are eligible for a contribution toward premium of 80% of the standard plan or 100% of the least costly alternate plan, whichever is less.

J. Time Table and Due Dates For Annual Information Submittals to the Department of Employee Trust Funds

(Note: Unless otherwise specified, if the "Due Date" listed below falls on a Saturday, materials should be received by ETF the previous Friday, If the "Due Date" falls on a Sunday, materials should be received by ETF the following Monday.)

Due Date 2003 (Receipt by ETF)	Information Due	Date Submitted
April 15	• New plans only. Proposal to participate in the program (Section II., I, page 1-16). Contract to be executed by plan/Board. (Section 3)	
April 30	• Estimated premium rate proposal for next calendar year. This is due by May 1 of odd-numbered years (e.g., 2001, 2003) to coincide with the timing of collective bargaining	
May 15	• For PPPs and POSs – Any change to the level of benefits for out-of-plan services for the next benefit year must be submitted.	
June 1	• Documentation of financial stability (2 copies each): 1. Balance sheet 2. Statement of Operations 3. Annual audited financial statement • Preliminary identification of planned service areas by county for the next calendar year. • Initial data files of: (1) Addendum 2 provider counts and (2) primary physicians and specialty providers under contract by county (and zip code) for the next calendar year. • Addendum 1C – Utilization Review Worksheet.	
June 1 or date due to NCQA, whichever is later	• HEDIS information is required for the prior calendar year.	
June 15	• Plan Utilization and Rate Review Information (Addendum #1A). This information is to be mailed directly to: James A. Scearcy Deloitte & Touche 400 One Financial Plaza 120 So Minnea And simultaneously e-mailed to sonya.sidky@etf.state.wi.us • Addendum 1B – Tables describing catastrophic cases. (Table 8)	
July 15	• If the plan offers dental coverage, final dental plan benefit description is due if the dental coverage is first being offered or if there is any benefit change to the dental benefit.	

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Due Date 2003 (Receipt by ETF)	Information Due	Date Submitted
July 30	• Final data files of: 1) Addendum 2 and 2) providers under contract by county (and zip code) for the next calendar year. (Note: This date will be moved up by one week at the discretion of the Department's Data Manager for any individual plans for whom the June 1 data submission was unacceptable.) • Premium rate quotations for next calendar year. (Annually, about July 15, each plan will be provided with a rate quotation form and a special mailing envelope.)	
August 13	• Text to be printed in the plan description section of the annual Dual-Choice brochures. Plans must use the format provided by the Department. • Request for state employee home address labels (by zip code) for plan use during Dual-Choice Enrollment Period. • The plan's address and telephone number as it should appear in the Dual-Choice brochure.	
August 16 (Approximately)	• Final best premium bid or withdrawal notice due. • Due date for a plan to notify the Department that it is terminating its contract with the Board.	
August 24?	• Group Insurance Board meeting to set the Standard plans' premium rates (fee-for-service plan) and to open alternate plan rate submittals.	
September 1	• Proof copies of informational material that the plan intends to distribute to state/local employees during Dual-Choice Enrollment period. • Complete list of the plan's key contacts as stated in Section II., G., 3., j.	
September 15	• Draft of dental benefit description that will be provided to members if the plan offers dental coverage. This must include the exclusions and limitations. Department approval, prior to October 1, is required. • Draft of letter the plan will mail to current subscribers summarizing dental benefit and provider network changes for the new calendar year, as well as description of referral and prescription drug authorization requirements. Provider network changes must include a list of providers, clinics and hospitals that will no longer be plan providers in the following calendar year, in the format established by the Department. Department approval, prior to October 1, is required. **THIS NOTICE MUST BE MAILED TO SUBSCRIBERS BY OCTOBER 1, WITH FORWARDING REQUESTED.** • In order to lessen participant confusion during the Dual-Choice Enrollment period, the plan, its representatives and informational materials shall advise participants that only those providers listed in its current provider directory should be considered when making their health plan choice.	

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Due Date 2003 (Receipt by ETF)	Information Due	Date Submitted
September 30	• Completed contract, signed and dated. This must include two (2) copies of the contract and all applicable attachments. • Provide five (5) copies of all informational materials in final form to the Department. • Final dental benefit/exclusion description which will be provided to members if the plan offers dental coverage.	
October 1 (approx)	• Dual-Choice Kick-off meeting in Madison. Address labels for state employees for plan informational mailings will be available.	
October 8	• Confirmation that letter to current subscribers summarizing changes for the new calendar year has been sent.	
October 6 - 24	• Dual-Choice Enrollment Period.	
December 15, 2003 – January 15, 2004	• Send to appropriate subscribers a standardized letter, designed by the Department, requesting verification of student status.	
January 2, 2004	• Identification cards must be issued to all new Dual-Choice enrollees. Explanation of referral and grievance procedures must be included.	
January 15, 2004	• Issuance of new ID cards, if applicable, to continuing subscribers. Letter to ETF confirming completion is also due.	
March 1, 2004	• Report summary of grievances received during previous calendar year period, by number and type. [Section I., G., 3., d., (3.)] • Report to employing agency any subscribers whose level of coverage has changed (e.g., family to single) as a result of annual the student status questionnaire.	
April 1, 2004	• A Quality Improvement plan in the format set forth by the Department.	

4. Prescription Drugs

This benefit includes outpatient prescriptions ordered by an attending physician or other qualified medical professional, including the dispensing fee. Services are counted as the number of scripts.

5. Private Duty Nursing/Home Health

This benefit includes private nursing and home health visits if required by the attending physician and not representing custodial care. Services are counted as the number of procedures.

6. Ambulance

(HCPCS Codes A0000-A0999)

This benefit includes professional ambulance service. Services are counted as the number of procedures.

7. Durable Medical Equipment/Prosthetics

(HCPCS Codes A4610-A4640, B9000-B9999, E0100-E1702, L0100-L9999, Q0036-Q0046, Q0081, V5011-V5299, V5336)

This benefit includes appliances, equipment, and prosthetic devices. Appliances and equipment include braces (orthotics), canes, crutches, glucosan, glucometer, intermittent positive pressure machines, rib belt for treatment of an accident or illness, walker, wheel chairs, etc. Prosthetics includes artificial parts that replace a missing body part or improve a body function (i.e., artificial limb, heart valve, and medically necessary reconstruction). Services are counted as the number of items.

8. Laboratory

(CPT Codes 36415, 80002-88299, 88400-89399; HCPCS Codes P0000-P9999)

This benefit includes both the professional and technical component of non-physician laboratory services when these services are billed together. Services are counted as the number of procedures.

9. Prescription Drug

a. Excluding smoking cessation (All drugs excluding those with GPI code 62-10-00 through 62-10-99.)

   This benefit includes all prescription drug claims, while excluding those associated with smoking cessation. A complete list of NDC codes for smoking cessation drugs is available upon request.

b. Including smoking cessation (All drugs with GPI code 62-10-00 through 62-10-99.)

   This benefit includes all prescription drug claims associated with smoking cessation. A complete list of NDC codes for smoking cessation is available upon request.

Plan Name _____

ADDENDUM 1C: Utilization Review Worksheet

Plans must demonstrate effective and appropriate means of monitoring and directing patient's care by participating physicians. (Utilization Review; UR)

Check YES, if requirement is in place. Plans must certify that these (or equivalent) procedures are in place. If "NO" is answered to any question, plans must provide, in writing, a description of the equivalent process.

YES	NO	
☐	☐	Members are required to select primary care physicians who coordinate the member's care in the HMO or PPP's and approve referrals to specialists.
☐	☐	Written guidelines that physicians must follow to comply with the HMO's or PPP's UR program (for IPA model HMOs).
☐	☐	Formal UR program consisting of preadmission review, concurrent review, discharge planning and individual case management.
☐	☐	Established procedures for review determinations, including qualified staff (e.g., primary reviewer is licensed nurse), physician reviews all program denials and patient appeals procedure.
☐	☐	Authorization procedure for referral to non-plan providers and monitoring of physician referral patterns.
☐	☐	Procedure to monitor emergency admissions to non-plan hospitals.
☐	☐	Prescription drug utilization controls such as use of formulary (list of approved prescription drugs) and review of individual physician prescribing patterns.
☐	☐	Retrospective UR procedures to review the appropriateness of care provided, utilization trends and physician practice patterns.
☐	☐	Send correspondence to network hospitals and require those in metropolitan areas to complete the Leapfrog survey and educate those in rural areas about Leapfrog.

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ADDENDUM 2: PLAN QUALIFICATIONS/PROVIDER GUARANTEE

Providers Under Contract Physically Located in Each Major City/County/Zip Code
State and Local Employees

Using the format provided by ETF, record the number of providers under contract sorted by zip-code who are physically located within each county and major city in the service area. Major cities are those that have over 33% of the county population. Those cities are Antigo, Appleton, Ashland, Eau Claire, Florence, Fond du Lac, Green Bay, Janesville, Kenosha, LaCrosse, Madison, Manitowoc, Menomonie, Merrill, Milwaukee, Monroe, Oshkosh, Prairie du Chien, Racine, Sheboygan, Stevens Point, Sturgeon Bay, and Superior.

Provider Guarantee:
Providers listed here and/or on any of the plan's publications of providers are either under contract and available as specified in such publications for all of the ensuing calendar year or the plan will pay charges for benefits on a fee-for-service basis. Fee-for-service means the usual and customary charges the plan is able to negotiate with the provider while the subscriber is held harmless and indemnified. The intent of this provision is to allow patients of plan providers to continue appropriate access to any plan provider until the participant is able to change plans through the next dual-choice enrollment. This applies in the event a provider or provider group terminates its contract with the plan, except that loss of physicians due to normal attrition (death, retirement, a move from the service area;) or as a result of a formal disciplinary action relating to quality of care shall not require fee-for-service payment. If a participant is in her second or third trimester of pregnancy when the provider's participation in the plan terminates, the participant will continue to have access to the provider until the completion of postpartum care for the woman and infant. Providers also agree to accept new patients unless specifically indicated otherwise. When providers terminate their contractual relationship, subscribers must be notified by the plan prior to the Dual-Choice Enrollment period. Plans shall keep a record of this notification mailing and shall provide documentation, by subscriber and indicating the mailing address used, upon the Department's request.

If a plan clinic or hospital closes during the contract year, participants using that facility must be notified, in writing, 30 days in advance of the closing. This notice may be provided by the provider. The notification must indicate the participant's options for other plan clinics or hospitals. If a physician leaves the plan mid-year, his or her patients must be notified, in writing, no less than 14 days prior to that event. In either instance, the subscriber must be advised of the provider guarantee.

This form must be filed annually by all current and new plans with the Department of Employee Trust Funds. The initial listing is due on June 3; the final copy is due on August 1. It is used to determine qualification for the plan's premium rate to be used in calculation of the employer contribution toward premium. Generally, those qualifications are:

1. The ratio of full time equivalent (FTE) primary physicians accepting new patients to total plan members in a country or major city is at least 1.0/2,000 with a minimum of 5 physicians/county or major city. The primary physicians counted for this qualification requirement must be able to admit patients to a plan hospital in the county where the plan is qualified.
2. There must be at least one general hospital per county or major city.
3. A pharmacy must be availabl[illegible] if applicable).
4. If optional dental coverage is [illegible] able in each county (or major city if applicable).

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5. A chiropractor must be available in each county (or major city if applicable).
This CONTRACT sets forth the terms and conditions for the PLAN to provide group health care BENEFITS for EMPLOYEES, ANNUITANTS, and their DEPENDENTS eligible for coverage offered by the Group Insurance Board pursuant to Wis. Stat. § 40.51.

ARTICLE 1 DEFINITIONS

The following terms, when used and capitalized in this CONTRACT are defined and limited to that meaning only:

1.1 "ANNUITANT" means any retired EMPLOYEE of the State of Wisconsin: receiving an immediate annuity under the Wisconsin Retirement System; or a terminated EMPLOYEE with 20 years of creditable service or a disability benefit under Wis. Stats. § 40.65.

1.2 "BENEFITS" means those items and services as listed in Attachment A.

1.3 "BOARD" means the Group Insurance Board.

1.4 "CONTRACT" means this document which includes all attachments, supplements, endorsements or riders.

1.5 "DEPARTMENT" means the Department of Employee Trust Funds.

1.6 "DEPENDENT" means the spouse of the SUBSCRIBER and his or her unmarried children (including legal wards who become legal wards of the SUBSCRIBER prior to age 19 but not temporary wards, adopted children or children placed for adoption as provided for in Wis. Stats. § 632.896, and stepchildren), who are dependent on the SUBSCRIBER (or the other parent) for at least 50% of their support and maintenance and meet the support tests as a dependent for federal income tax purposes (whether or not the child is claimed), and children of those dependent children until the end of the month in which the dependent child turns age 18. Children born outside of marriage become dependents of the father on the date of the court order declaring paternity or on the date the acknowledgement of paternity is filed with the Department of Health and Family Services or equivalent if the birth was outside the state of Wisconsin. The effective date of coverage will be the date of birth if a statement of paternity is filed within 60 days of the birth. A spouse and stepchildren cease to be a DEPENDENTS at the end of the month in which a divorce decree is entered. Wards cease to be DEPENDENTS at the end of the month in which they cease to be wards. Other Children cease to be DEPENDENTS at the end of the calendar year in which they turn 19 years of age or cease to be dependent for support and maintenance, or at the end of the month in which they marry, whichever occurs first, except that:

(1) Children age 19 or over who are full-time students, if otherwise eligible, cease to be DEPENDENTS at the end of the calendar year in which they cease to be full-time students or in which they turn age 25, whichever occurs first.

(2) Student status includes any intervening vacation period if the child continues to be a full-time student. Student means a person who is enrolled in and attending an institution, which provides a schedule of courses or classes and whose principal activity is the procurement of an education. Full-time status is defined by the institution in which the student is enrolled. Per the Internal Revenue Code, the term "school" includes elementary schools, junior and senior high schools, colleges, universities, and technical, trade, and mechanical s[State Contract, Page 3-5]he-job training courses, correspondence schools, intersession courses, and night schools.

(3) If otherwise eligible children are, or become, incapable of self-support on account of a physical or mental disability which can be expected to be of long-continued or indefinite duration, they continue to be or resume their status of DEPENDENTS regardless of age or student status, so long as they remain so disabled. The child must have been previously covered as an eligible Dependent under this program in order to resume
coverage. The PLAN will monitor mental or physical disability at least annually and will assist the DEPARTMENT in making a final determination if the subscriber disagrees with the initial PLAN determination.

(4) A child who is considered a DEPENDENT ceases to be a DEPENDENT on the date the child becomes insured as an eligible EMPLOYEE.

(5) Any DEPENDENT eligible for BENEFITS will be provided BENEFITS based on the date of eligibility not on the date of notification to the PLAN.

1.7 "EFFECTIVE DATE" means the date, as certified by the DEPARTMENT and shown on the records of the PLAN in which the PARTICIPANT becomes enrolled and entitled to the BENEFITS specified in this CONTRACT.

1.8 "EMPLOYEE" means an eligible EMPLOYEE of the State of Wisconsin as defined under Wis. Stat. § 40.02 (25) (a), 1., 2., or (b), 1m., 2., 2g., 2m., or 8.

1.9 "FAMILY SUBSCRIBER" means a SUBSCRIBER who is enrolled for family coverage and whose DEPENDENTS are thus eligible for BENEFITS.

1.10 "INDIVIDUAL SUBSCRIBER" means a SUBSCRIBER who is enrolled for personal coverage only and whose DEPENDENTS, if any, are thus not eligible for BENEFITS.

1.11 "INPATIENT" means a PARTICIPANT admitted as a bed patient to a health care facility or in 24-hour home care.

1.12 "LAYOFF" means the same as "leave of absence" as defined under Wis. Stat. § 40.02 (40).

1.13 "PARTICIPANT" means the SUBSCRIBER or any of the SUBSCRIBER'S DEPENDENTS who have been specified by the DEPARTMENT to the PLAN for enrollment and are entitled to BENEFITS.

1.14 "PLAN" means the alternate health care plan signatory to this agreement.

1.15 "PREMIUM" means the rates shown on ATTACHMENT C plus the administration fees required by the BOARD. Those rates may be revised by the PLAN annually, effective on each succeeding January 1 following the effective date of this contract.

1.16 "STANDARD PLAN" means the fee-for-service health care plan offered by the BOARD.

1.17 "SUBSCRIBER" means an EMPLOYEE, ANNUITANT, or his or her surviving DEPENDENTS, who have been specified by the DEPARTMENT to the PLAN for enrollment and who is entitled to BENEFITS.

ARTICLE 2 ADMINISTRATION

2.1 AMENDMENTS.

This CONTRACT may be amended by written agreement between the PLAN and the BOARD at any time.

2.2 COMPLIANCE WITH THE CONTRACT AND APPLICABLE LAW.

(1) In the event of a conflict between this CONTRACT and any applicable federal or state statute, administrative rule, or regulation; the statute, rule, or regulation will control.

(2) In connection with the performance of work under this contract, the contractor agrees not to discriminate against employees or applicants for employment because of age, race, religion, creed, color, handicap, physical condition, developmental disability as defined in Wis. Stat. § 51.01(5); marital status, sex, sexual orientation, national origin, ancestry, arrest record, conviction record; or membership in the national guard, state defense force, or any reserve component of the military forces of the United States or this state. The PLAN agrees to maintain a written affirmative action plan, which shall be available upon request to the DEPARTMENT.

(3) The PLAN shall comply with all applicable requirements and provisions of the Americans with Disabilities Act (ADA) of 1990. Evidence of compliance with ADA shall be made available to the DEPARTMENT upon request.

(4) In cases where premium rate negotiations result in a rate that the Board's actuary determines to be inadequately supported by the data submitted by the PLAN, the BOARD may take any action up to and including limiting new enrollment into that PLAN.

2.3 CLERICAL AND ADMINISTRATIVE ERROR.

(1) Except for the constructive waiver provision of Section 3.6, no clerical error made by the employer, the DEPARTMENT or the PLAN shall invalidate CONTRACT BENEFITS of a PARTICIPANT otherwise validly in force, nor continue such BENEFITS otherwise validly terminated.

(2) Except for the constructive waiver provision of Section 3.6, if an EMPLOYEE or ANNUITANT has made written application during a prescribed enrollment period for either individual or family coverage and has authorized the PREMIUM contributions, CONTRACT BENEFITS shall not be invalidated solely because of the failure of the employer or the DEPARTMENT, due to clerical error, to give proper notice to the PLAN of such EMPLOYEE'S application.

(3) In the event that an employer erroneously continues to pay the PREMIUM for an EMPLOYEE who terminates employment, refunds of such premiums shall be limited to no more than two months of premiums paid.

(4) Except in cases of fraud, unreported death, misrepresentation, or when required by Medicare, retrospective adjustments to premium or claims for coverage not validly in force shall not be made prior to January 1 of the previous calendar year. In situations where coverage is validly in force, the employer has not paid premium, and the employee does not have a required contribution, retroactive premium will be made for the entire period of coverage, regardless of the discovery date.

(5) In the event that an employer determines an effective date under Wis. Stat. § 40.51 (2) based on information obtained from the DEPARTMENT available at the time the application is filed, such application shall not be invalidated solely as a result of an administrative error in determining the proper effective date of employer contribution. No such error will result in providing coverage for which the employee would otherwise not be entitled.

2.4 REPORTING.

(1) EMPLOYEES and ANNUITANTS shall become or be SUBSCRIBERS if they have filed with the employer or DEPARTMENT, if applicable, an application in the form prescribed by the DEPARTMENT, and are eligible in accordance with this contract, the law, the administrative rules, and regulations of the DEPARTMENT.

(2) On or before the effective date of this CONTRACT, the DEPARTMENT shall furnish a report to the PLAN showing the INDIVIDUAL SUBSCRIBERS and FAMILY SUBSCRIBERS entitled to BENEFITS under the CONTRACT during the first month that it is in effect, and such other reasonable data as may be necessary for PLAN administration. The DEPARTMENT shall furnish like reports for each succeeding month that the CONTRACT is in effect.

(3) Monthly or upon request by the DEPARTMENT, the PLAN shall submit a data file (or audit listing, if requested by the DEPARTMENT) to establish or update the DEPARTMENT'S membership files. The PLAN shall submit these files using the SUBSCRIBER identifiers (currently Social Security Number) determined by the DEPARTMENT. The PLAN shall create separate files for SUBSCRIBERS and DEPENDENTS, in a format specified by the DEPARTMENT (currently fixed length ASCII records), and submit them to the DEPARTMENT or its designated database administrator. The DEPARTMENT will submit to the PLAN error reports showing SUBSCRIBER and DEPENDENT records failing one or more edits to which the electronic updates are subjected, after which the PLAN shall correct and resubmit the failed records with its next monthly update.

(4) Unless individually waived by the BOARD, each PLAN will submit the current applicable version of the Health Plan Employer Data and Information Set (HEDIS) by June 1 for the previous calendar year. The data set will be for both the entire PLAN membership and the state group membership where applicable. The data will be supplied in a format specified by the DEPARTMENT.

(5) PLANS shall submit all reports and comply with all material requirements set forth in the GUIDELINES or the BOARD may terminate the contract between the PLAN and the BOARD at the end of the calendar year, restrict new enrollment into the PLAN, or the Department may impose other sanctions as deemed appropriate. These sanctions may include, but are not limited to, financial penalties of no more than $100 per day per occurrence, to begin on the 5th day following the date notice of non-compliance is delivered to the PLAN. Such financial penalty will not exceed $5000 per occurrence. The penalty may be waived if timely submission is prevented for due cause, as determined by the DEPARTMENT.

2.5 BROCHURES AND INFORMATIONAL MATERIAL.

(1) The PLAN shall provide the SUBSCRIBER with identification cards indicating the effective date of coverage, a listing of all available providers, and their available locations and pre-authorizations and referral requirements. If the PLAN offers dental coverage, it must provide the PARTICIPANT a description of the dental network benefits, limitations and exclusions.

(2) All brochures and other informational material as defined by the DEPARTMENT must receive approval by the DEPARTMENT before being distributed by the PLAN. Five (5) copies of all informational materials in final form must be provided to the DEPARTMENT. At its discretion, the DEPARTMENT may designate a common vendor, which shall provide the annual Description of Benefits and such other information, or services it deems appropriate, including audit services. The vendor shall be reimbursed by the PLAN at cost, but not to exceed $.12 per member per month. PLANS will be advised of amount of this charge prior to the due date for premium bids. The PLAN will be responsible for any costs assessed to the PLAN even if the PLAN is withdrawing from the program.

(3) Upon request, the PLAN will provide information on programs, services, and activities in alternate formats to PARTICIPANTS with qualified disabilities as defined by the Americans with Disabilities Act (ADA) of 1990. All brochures and informational material shall include the following statement:

> "[NAME OF PLAN] does not discriminate on the basis of disability in the provision of programs, services, or activities. If you need this printed material interpreted or in an alternative format, or need assistance in using any of our services, please contact [CONTACT PERSON OR OFFICE. INCLUDE PHONE NUMBER AND TTY NUMBER IF AVAILABLE]."

(4) If erroneous or misleading information is sent to SUBSCRIBERS by a provider or subcontractor, the DEPARTMENT may require a plan mailing to correctly inform PARTICIPANTS.

2.6 FINANCIAL ADMINISTRATION.

Prior to the beginning of any calendar month, the DEPARTMENT shall transmit to the PLAN that month's estimated PREMIUM for SUBSCRIBERS who are properly enrolled less the administration fees required by the BOARD.

2.7 INSOLVENCY (OR SOLVENCY).

(1) ATTACHMENT B provides documentation that, in the event the PLAN becomes insolvent or otherwise unable to meet the financial provisions of this CONTRACT, bonding or reinsurance exists to pay those obligations. Such bonding or reinsurance shall continue BENEFITS for all PARTICIPANTS at least until the end of the calendar month in which insolvency is declared. For a PARTICIPANT then confined as an INPATIENT, BENEFITS shall continue until the confinement ceases, the attending physician determines confinement is no longer medically necessary, the end of 12 months from the date of insolvency, or the CONTRACT maximum is reached, whichever occurs first. The DEPARTMENT will establish enrollment periods during which subscribers may transfer to another PLAN.

(2) The PLAN shall submit to the DEPARTMENT on an annual basis, information on its financial condition including a balance sheet, statement of operations, financial audit reports, and utilization statistics.

2.8 DUE DATES.

(1) Reports and remittances from employers required in the administration of the group health insurance program shall be submitted to the DEPARTMENT no later than the 20th day of the calendar month for the following month's coverage.

(2) The employer shall immediately forward to the PLAN the "carrier advance registration" copy of applications filed by newly eligible EMPLOYEES. The PLAN shall issue ID cards based upon the carrier advance registration copy of the applications.

2.9 CONTINUATION OR CONVERSION OF INSURANCE.

(1) Except when coverage is canceled, PREMIUMS are not paid when due, coverage is terminated as permitted by state or federal law, or the employer is not notified of the participant's loss of eligibility as required by law, a PARTICIPANT who ceases to be eligible for BENEFITS may elect to continue group coverage for a maximum of 36 months from the date of the qualifying event or the date of the employer notice, whichever is later. Application must be received by the DEPARTMENT within 60 days of the date the PARTICIPANT is notified by the employer of the right to continue or 60 days from the date coverage ceases, whichever is later. The PLAN shall bill the continuing PARTICIPANT directly for required premiums.

If the PARTICIPANT does not reside in a county listing a primary physician for the SUBSCRIBER'S PLAN at the time continuation coverage is elected, the PARTICIPANT may elect a participating plan in the county where the PARTICIPANT resides.

(2) Such PARTICIPANT may also elect to convert to individual coverage, without underwriting, if application is made directly to the PLAN within 30 days after termination of group coverage. The PARTICIPANT shall be eligible, to apply for the direct pay conversion contract then being issued provided coverage is continuous and the premiums then in effect for the conversion contract are paid without lapse. The right to a conversion contract will also be offered when the PARTICIPANT reaches the maximum length of continuation of group coverage.

(3) Children born or adopted while the parent is continuing group coverage may be covered for the remainder of the parent's period of continuation. A PARTICPANT who has single coverage must elect family coverage within 60 days of the birth or adoption in order for the child to be covered. The PLAN will automatically treat the child as a qualified dependent as required by COBRA and provide any required notice of COBRA rights.

2.10 GRIEVANCE PROCEDURE.

(1) Any dispute about health insurance benefits or claims arising under the terms and conditions of the agreement shall first be submitted for resolution through the PLAN'S internal grievance process and may then, if necessary, be submitted to the DEPARTMENT. The PARTICIPANT may file a complaint with the Manager of Quality Assurance for review. The PARTICIPANT may also request a departmental determination. The determination of the DEPARTMENT is final and not subject to further review unless a timely appeal of the determination by the DEPARTMENT is submitted to the BOARD, as provided by Wis. Stat. § 40.03 (6) (i) and Wis. Admin. Code § ETF 11.01 (3). The decision of the BOARD is reviewable only as provided in Wis. Stat. § 40.08 (12).

(2) The PARTICIPANT may also request an independent review § INS 18.11 Wis. Adm. Code. In this event, the DEPARTMENT must be notified by the PLAN of the PARTICIPANT'S request at the same time the Office of the Commissioner of Insurance is notified in a manner that is defined by the DEPARTMENT. In accordance with § INS 18.11 Wis. Adm. Code any determination by an Independent Review Organization is final and binding. PARTICIPANTS have no further right to administrative review by the DEPARTMENT or BOARD once the Independent Review Organization decision is rendered.

(3) The plan's grievance procedure must be included as ATTACHMENT E. At a minimum, the grievance process must comply with Wis. Adm. Code § INS 18.3 or any other statutes or administrative codes that relate to managed care grievances. This extends to any "carve-out" services (e.g., dental, chiropractic, mental health, prescription drug administrators).

(4) The PARTICIPANT must be provided with notice of the right to grieve and a minimum period of 60 days to file a grievance after written denial of a BENEFIT or occurrence of the cause of the grievance.

(5) Investigation and resolution of any grievance will be initiated within 5 days of the date the grievance is filed by the complainant in an effort to effect early resolution of the problem. Grievances related to an urgent health concern will be handled within four business days of the PLAN'S receipt of the grievance.

(6) Notification of Determination Rights.

In the final grievance decision letters, the PLAN shall inform PARTICIPANTS of their right to request a DEPARTMENT review of the grievance committee's final decision. In the event they disagree with the final decision, PARTICIPANTS may submit a written request to the DEPARTMENT within 60 days of the final grievance decision letter. The DEPARTMENT will review, investigate, and attempt to resolve complaints on behalf of PARTICIPANTS. Upon completion of the DEPARTMENT review and in the event that PARTICIPANTS disagree with the outcome, PARTICIPANTS may file a written request for determination from the DEPARTMENT. The request must be received by the DEPARMENT within 60 days of the date of the DEPARTMENT final review letter.

(7) Provision of Complaint Information.

All information and documentation pertinent to any decisions or actions taken regarding any PARTICIPANT complaint or grievance by a PLAN shall be made available to the DEPARTMENT upon request. Information may include complete copies of grievance files, medical records, consultant reports, customer service contact worksheets or any other documentation the DEPARTMENT deems necessary to review a PARTICIPANT complaint resolving disputes or when formulating determinations. Such information must be provided within fifteen working days, or by an earlier date as requested by the DEPARTMENT.

(8) Notification of Legal Action.

If a PARTICIPANT files a lawsuit naming the PLAN as a defendant, the PLAN must notify the DEPARTMENT'S chief legal counsel within ten working days of notification of the legal action. This requirement does not extend to cases of subrogation.

(9) If a departmental determination overturns a PLAN'S decision on a PARTICIPANT'S grievance, the PLAN must comply with the determination within 90 days of the date of the determination or a $500 penalty will be assessed for each day in excess of 90 days. As used in this section, "comply" means to take action as directed in the departmental determination or to appeal the determination to the BOARD within 90 days.

ARTICLE 3 COVERAGE

3.3 SELECTION OF COVERAGE.

(1) If coverage is not elected under this section, it shall be subject to the deferred coverage provision of section 3.10. Except as otherwise provided in this section, coverage shall be effective on the first day of the month, which begins on, or after the date the application is received by the employer.

(2) (a) An EMPLOYEE shall be insured if a completed DEPARTMENT application form is received by the employer within 30 days of hire, to be effective on the first day of the month following receipt of the application by the employer, or prior to becoming eligible for employer contributions to be effective upon becoming eligible for employer contribution. In accordance with Wis. Stats. § 40.51 (2), an EMPLOYEE who enrolls for single coverage within 30 days of hire, may change to family coverage during the enrollment period offered as a result of becoming eligible for employer contribution toward premium. The EMPLOYEE and his or her DEPENDENTS shall not be subject to any waiting periods or evidence of insurability requirements.

(b) Notwithstanding paragraph (2) a. above, an EMPLOYEE who is not insured but who is eligible for an employer contribution under Wis. Stat. § 40.05 (4) (ag)1 may elect coverage prior to becoming eligible for an employer contribution under Wis. Stat. § 40.05 (4) (ag)2 to be effective upon the date of the increase in the employer contribution. An EMPLOYEE who does not file an application at this time but who files within 30 days after the date of hire which resulted in the increase in employer contribution shall have coverage effective on the first day of the month following receipt of the application by the employer.

(3) (a) An EMPLOYEE eligible and enrolled for individual coverage only may change to family coverage effective on the date of change to family status if an application is received by the employer within 30 days after the date of the change to family status. The difference in PREMIUM between individual and family coverage for that month shall be due only if the change is effective before the 16th of the month. ANNUITANTS shall submit the application to the DEPARTMENT.

(b) Notwithstanding paragraph 3 (a) above, the birth or adoption of a child to a subscriber under a single plan, who was previously eligible for family coverage, will allow the subscriber to change to family coverage if an application is received by the employer within 60 days of the birth, adoption or placement for adoption.

(4) In addition to any enrollment period required under Wis. Stats. § 40.05 (4g), an EMPLOYEE enrolled for coverage at the time of being called into active military service whose coverage lapses shall be entitled to again enroll upon resumption of eligible employment with the same employer subject to the following:

(a) Employment is resumed within 90 days after release from active military service, and

(b) The application for coverage is received by the employer within 30 days after return to employment.

(c) An EMPLOYEE who is enrolled for individual coverage and becomes eligible for family coverage between the time of being called into active military service and the return to employment may elect family coverage within 30 days upon re-employment without penalty.

employee's affected under Wis. Stat. § 40.02 (25) (b) (6g) coverage will begin on the first of the month following the DEPARTMENT'S receipt of the health insurance application.

(9) Eligible retired employees or former employees of the State who have re-enrolled under section 3.10 (4) of the GUIDELINES may select any offered plan.

3.4 DUAL-CHOICE ENROLLMENT PERIODS.

(1) The BOARD shall establish enrollment periods which shall permit eligible and currently covered EMPLOYEES and ANNUITANTS to transfer coverage to any health care coverage PLAN offered by the BOARD pursuant to Wis. Stat. § 40.51.

Unless otherwise provided by the BOARD, the dual-choice enrollment period shall be held once annually in the fall of each year with coverage effective the following January 1.

(2) If a SUBSCRIBER has not received a dual-choice enrollment opportunity as determined by the DEPARTMENT, an enrollment opportunity may be offered prospectively.

(3) An EMPLOYEE who returns from leave of absence during which coverage lapsed and which encompassed the entire previous dual-choice enrollment period will be allowed a Dual-Choice enrollment provided an application is filed during the 30 day period which begins on the date the EMPLOYEE returns from leave of absence.

(4) An EMPLOYEE or ANNUITANT may also change plans if the SUBSCRIBER moves from his/her residence out of the plan's service area for a minimum of three months. A move from a medical facility to another facility by the subscriber is not considered a residential move. An application must be filed during the 30 day period, which begins on the date the SUBSCRIBER moves.

(5) A subscriber under (3) and (4) above who does not file an application to change plans within this 30-day enrollment period, may change only to the STANDARD PLAN, and shall be subject to the pre-existing condition clause contained in the STANDARD PLAN Contract. Coverage shall be effective the first day of the calendar month, which begins on or after the date the application is received by the employer.

(6) The PLAN shall accept any individual who transfers from one health care coverage plan to another or from individual to family coverage without requiring evidence of insurability, waiting periods, or exclusions for pre-existing conditions as defined in INS § 3.31 (3), Wisconsin Administrative Code.

(7) If the PLAN offers more than one network to PARTICIPANTS and the service areas of those networks change on January 1st, a SUBCRIBER who failed to make a Dual-Choice election to change networks in order to maintain access to his or her current providers may still change to the appropriate network within that same PLAN. The effective date of the change in networks is effective on January 1st or the first day of the month after the employer receives the SUBSCRIBER'S request to change networks, whichever is later.

3.5 INITIAL PREMIUMS.

When coverage becomes effective, multiple PREMIUM payments may be required initially to make PREMIUM payments current.

3.15 COVERAGE OF EMPLOYEES AFTER RETIREMENT.

(1) Coverage for an insured EMPLOYEE shall be continued if the EMPLOYEE:

(a) Retires on an immediate annuity as defined under Wis. Stat. § 40.02 (38),

(b) EMPLOYEES who receive a disability annuity and remain continuously covered under the group shall be considered to have met the requirements for an immediate annuity for health insurance purposes. If the disability annuity terminates and the PARTICPANT continues to meet the definition of eligible EMPLOYEE under Wis. Stat. § 40.02 (25), the individual is eligible to continue using accumulated leave credits until exhausted under Wis. Stat. § 40.05 (4) (b).

(c) Terminates employment after attaining 20 years of creditable service. An application for continued coverage must be filed with the DEPARTMENT within 90 days of the termination of employment if the terminated employee is not eligible for an immediate annuity.

(d) Receives a long-term disability benefit as provided for under Wis. Admin. Code § ETF 50.40.

(2) Coverage for a person otherwise eligible who is entitled to:

(a) and applies for an immediate annuity under Wis. Stat. § 40.02 (38), may be reinstated even if during any period preceding retirement, insurance has not been in effect while no earnings were received, or insurance has been continued under COBRA continuation through the State's health insurance program. An application for health insurance must be received by the DEPARTMENT within 30 days after the date of the DEPARTMENT'S benefit approval notice. Coverage shall be effective the first day of the calendar month which occurs on or after the date the application for health insurance has been received.

(b) and applies for an LTDI benefit under Wis. Admin. Code § ETF 50.40, or a duty disability benefit under Wis. Stat. § 40.65, may be reinstated even if, during the period proceeding the benefit approval, no insurance was in effect while no earnings were received, or insurance has been continued under COBRA continuation through the State's health insurance program. An application for health insurance must be received by the DEPARTMENT within 30 days after the date of the DEPARTMENT'S benefit approval notice. Coverage shall be effective the first day of the calendar month which occurs on or after the date the application for health insurance has been received.

(3) The DEPARTMENT may authorize PREMIUM payments to be made directly to the PLAN where circumstances require such. Failure to make required PREMIUM payments by the due dates established by the PLAN and approved by the DEPARTMENT shall cause the health care coverage to be cancelled.

3.16 COVERAGE OF ANNUITANTS AND SURVIVING DEPENDENTS ELIGIBLE FOR MEDICARE.

(1) Each insured ANNUITANT, their DEPENDENTS or surviving DEPENDENTS who becomes insured under federal plans for hospital and medical care for the aged (Medicare) may continue to be insured, but at reduced PREMIUM rates as specified by the BOARD.

(2) The reduction in PREMIUM shall be effective on the first day of the calendar month which begins on or after the date the Medicare hospital and medical insurance benefits (Parts A and B) become effective.

(3) Except in cases of fraud which shall be subject to section 3.18(5), coverage for any person who does not enroll for the voluntary medical insurance portion of the federal program when it is first available as the primary carrier shall be limited in accordance with Uniform Benefits IV., A., 12., b.

(4) Enrollment under the federal plans for hospital and medical care for the aged (Medicare) by EMPLOYEES and ANNUITANTS who are eligible for those programs is waived if the EMPLOYEE remains covered as an active employee of the state. Enrollment in Medicare Part B is required for the EMPLOYEE or DEPENDENTS at the first Medicare enrollment period after active employment ceases. If an ANNUITANT, or an ANNUITANT'S spouse, is covered under an active employee's group health insurance policy with another employer and that policy is the primary payor, the ANNUITANT or the ANNUITANT'S spouse covered under that policy may also defer enrollment in Medicare Part B (to the extent allowed by federal law) under this provision and shall pay the Medicare rates for coverage under this program.

(5) Enrollment under the federal plans for hospital care for the aged (Medicare) by EMPLOYEES, ANNUITANTS and their dependents who are eligible for those programs is waived if the insured EMPLOYEE, ANNUITANT, or DEPENDENT is required to pay a premium to enroll in the hospital portion of Medicare (Part A). However, if Part A is not elected, the reduced premium rate is not available.

(6) If a Medicare coordinated family premium category has been established for a family, and one or more family members enrolled in both parts of Medicare dies, the family premium category in effect shall not change solely as a result of the death.

(7) If the EMPLOYEE, ANNUITANT, or DEPENDENT is eligible for Medicare due to permanent kidney failure or end-stage renal disease, this PLAN shall pay as the primary payor for the first thirty months after he or she becomes eligible for Medicare due to the kidney disease, whether or not the EMPLOYEE, ANNUITANT, or DEPENDENT is enrolled in Medicare. The premium rate will be the non-Medicare rate during this period. Medicare becomes the primary payor after this thirty-month period. If the EMPLOYEE, ANNUITANT, or DEPENDENT has more than one period of Medicare enrollment based on kidney disease, there is a separate thirty-month period during which this PLAN will again be the primary payor. No reduction in premium is available for active employees under this section.

3.17 CONTRACT TERMINATION.

(1) The contract terminates on the date specified on the signatory page. The BOARD, by September 1, or the PLAN, by August 15, shall provide notice of its intent not to contract for the following contract year by providing notice to the other party. The PLAN must provide written notification to its SUBCRIBERS that it will not be offered during the next calendar year. This notification must be sent prior to the dual-choice enrollment period.

(2) If the PLAN terminates this CONTRACT pursuant to sub. (1), any PARTICIPANT who is receiving BENEFITS as an INPATIENT on the date of termination shall continue to receive all BENEFITS otherwise available to INPATIENTS until the earliest of the following dates:

(a) The CONTRACT maximum is reached.

(b) The attending physician determines that confinement is no longer medically necessary.

(c) The end of 12 months after the date of termination.

(d) Confinement ceases.

(3) If the PLAN ceases to be offered after a PARTICIPANT has fully satisfied a deductible, which is required initially, but not in subsequent time periods, but prior to the completion of the treatment program, liability for such services remains the responsibility of the PLAN without requiring further PREMIUM payments. However, an acceptable alternative would be for the PLAN to refund the deductible amount to the SUBSCRIBER.

(4) If the BOARD terminates this CONTRACT pursuant to sub. (1), then all rights to BENEFITS shall cease as of the date of termination. The PLAN will cooperate with the BOARD in attempting to make equitable arrangements for continuing care of PARTICIPANTS who are INPATIENTS on the termination date. Such arrangements may include but are not limited to: transferring the patient to another institution; billing the BOARD a fee for service rendered; or permitting non-plan physicians to assume responsibility for rendering care. The overall intent is to be in the best interest of the patient.

(5) If the PLAN terminates this CONTRACT, the PLAN shall not again be considered for participation in the program under Wis. Stats. § 40.03 (6) (a) for a period of three contract years.

3.18 INDIVIDUAL TERMINATION OF COVERAGE.

(1) A PARTICIPANT'S coverage shall terminate on the earliest of the following dates:

(a) The effective date of change to another health care plan through the BOARD approved enrollment process.

(b) The expiration of the period for which PREMIUMS are paid when PREMIUMS are not paid when due. Pursuant to Federal law, if timely payment is made in an amount that is not significantly less than amount due, that amount is deemed to satisfy the PLAN'S requirement for the amount that must be paid. However, the PLAN may notify the PARTICIPANT of the amount of the deficiency and grant a reasonable time period for payment of that amount. Thirty days after the notice is given is considered a reasonable time period.

(c) The expiration of the 36 months for which the SUBSCRIBER is allowed to continue coverage, while on a leave of absence or LAYOFF expires, as provided in Section 3.12.

(d) The end of the month in which a notice of cancellation of coverage is received by the employer or by the DEPARTMENT in the case of an ANNUITANT.

(e) The definition of PARTICIPANT no longer applies (such as a dependent child's marriage, divorced spouse, etc.). If family coverage remains in effect and the employee fails to notify the employer of divorce, coverage for the ex-spouse ends the last day of the month in which notification occurs. The employer may collect premium retroactively from the subscriber if the divorce was not reported in a timely manner and there were no other eligible dependents for family coverage to remain in effect.

(f) The expiration of the 36 months for which the PARTICIPANT is allowed to continue under paragraph (4) as required by state and federal law.

This CONTRACT sets forth the terms and conditions for the PLAN to provide group health care BENEFITS for EMPLOYEES, ANNUITANTS, and their DEPENDENTS eligible for coverage offered to employers participating under the Wisconsin Retirement System by the Group Insurance Board pursuant to Wis. Stats. § 40.51 (7).

ARTICLE 1 DEFINITIONS

The following terms, when used and capitalized in this CONTRACT are defined and limited to that meaning only:

1.01 "ANNUITANT" means any retired EMPLOYEE of a participating employer: receiving an immediate annuity under the Wisconsin Retirement System; or a person with 20 years of creditable service who is eligible for an immediate annuity but defers application; or a person receiving an annuity through a program administered by the DEPARTMENT under Wis. Stat. § 40.19 (4) (a) or a benefit under Wis. Stats § 40.65.

1.02 "BENEFITS" means those items and services as listed in Attachment A.

1.03 "BOARD" means the Group Insurance Board.

1.04 "CONTRACT" means this document which includes all attachments, supplements, endorsements or riders.

1.05 "DEPARTMENT" means the Department of Employee Trust Funds.

1.06 "DEPENDENT" means the spouse of the SUBSCRIBER and his or her unmarried children (including legal wards who become legal wards of the SUBSCRIBER prior to age 19 but not temporary wards, adopted children or children placed for adoption as provided for in Wis. Stats. § 632.896, and stepchildren), who are dependent on the SUBSCRIBER (or the other parent) for at least 50% of their support and maintenance and meet the support tests as a dependent for federal income tax purposes (whether or not the child is claimed), and children of those dependent children until the end of the month of which the dependent child turns age 18. Adoptive children become dependents when placed in the custody of the parent. Children born outside of marriage become dependents of the father on the date of the court order declaring paternity or on the date the acknowledgement of paternity is filed with the Department of Health and Family Services or equivalent if the birth was outside the state of Wisconsin. The effective date of coverage will be the date of birth if a statement of paternity is filed within 60 days of the birth. A spouse and stepchildren cease to be a DEPENDENTS at the end of the month in which a divorce decree is entered. Wards cease to be DEPENDENTS at the end of the month in which they cease to be wards. Other Children cease to be DEPENDENTS at the end of the calendar year in which they turn 19 years of age or cease to be dependent for support and maintenance, or at the end of the month in which they marry, whichever occurs first, except that:

(1) Children age 19 or over who are full-time students, if otherwise eligible, cease to be DEPENDENTS at the end of the calendar year in which they cease to be full-time students or in which they turn age 25, whichever occurs first.

(2) Student status includes any intervening vacation period if the child continues to be a full-time student. Student means a person who is enrolled in and attending an institution, which provides a schedule of courses or classes and whose principal activity is the procurement of an education. Full-time status is defined by the institution in which the student is enrolled. Per the Internal Revenue Code, the term "school" includes elementary schools, junior and senior high schools, colleges, universities, and technical trade, and mechanical schools. It does not include on-the-job training courses, correspondence schools, intersession courses, and night schools.

(3) If otherwise eligible children are, or become, incapable of self-support on account of a physical or mental disability which can be expected to be of long-continued or indefinite duration, they continue to be or resume their status of DEPENDENTS regardless of age or student status, so long as they remain so disabled. The child must have been previously covered as an eligible Dependent under this program in order to resume coverage. The Plan will monitor mental or physical disability at least annually and will assist the DEPARTMENT in making a final determination if the subscriber disagrees with the initial plan determination.

(4) A child who is considered a DEPENDENT ceases to be a DEPENDENT on the date the child becomes insured as an eligible EMPLOYEE.

(5) Any DEPENDENT eligible for BENEFITS will be provided BENEFITS based on the date of eligibility not on the date of notification to the PLAN.

1.07 "EFFECTIVE DATE" means the date, as certified by the DEPARTMENT and shown on the records of the PLAN in which the PARTICIPANT becomes enrolled and entitled to the BENEFITS specified in this CONTRACT.

1.08 "EMPLOYEE" means an eligible employee as defined under Wis. Stats. § 40.02 (46) or 40.19 (4) (a), of an employer as defined under § 40.02 (28), Stats., other than the state, which has acted under Wis. Stats. § 40.51 (7), to make health care coverage available to its employees.

1.09 "FAMILY SUBSCRIBER" means a SUBSCRIBER who is enrolled for family coverage and whose DEPENDENTS are thus eligible for BENEFITS.

1.10 "INDIVIDUAL SUBSCRIBER" means a SUBSCRIBER who is enrolled for personal coverage only and whose DEPENDENTS, if any, are thus not eligible for BENEFITS.

1.11 "INPATIENT" means a PARTICIPANT admitted as a bed patient to a health care facility or in 24-hour home care.

1.12 "LAYOFF" means the same as "leave of absence" as defined under Wis. Stats. § 40.02 (40),

1.13 "PARTICIPANT" means the SUBSCRIBER or any of the SUBSCRIBER'S DEPENDENTS who have been specified by the DEPARTMENT to the PLAN for enrollment and are entitled to BENEFITS.

1.14 "PLAN" means the alternate health care plan signatory to this agreement.

1.15 "PREMIUM" means the rates shown on ATTACHMENT C which may be revised by the PLAN annually plus the administration fees required by the BOARD, effective on each succeeding January 1 following the effective date of this contract.

1.16 "STANDARD PLAN" means the fee-for-service health care plan offered by the BOARD.

1.17 "SUBSCRIBER" means an EMPLOYEE, ANNUITANT, or his or her surviving DEPENDENTS, who have been specified by the DEPARTMENT to the PLAN for enrollment and who is entitled to BENEFITS.

ARTICLE 2 ADMINISTRATION

2.1 AMENDMENTS.

This CONTRACT may be amended by written agreement between the PLAN and the BOARD at any time.

2.2 COMPLIANCE WITH THE CONTRACT AND APPLICABLE LAW

(1) In the event of a conflict between this CONTRACT and any applicable federal or state statute, administrative rule, or regulation; the statute, rule, or regulation will control.

(2) In connection with the performance of work under this contract, the contractor agrees not to discriminate against employees or applicants for employment because of age, race, religion, creed, color, handicap, physical condition, developmental disability as defined in Wis. Stats. § 51.01 (5); marital status, sex, sexual orientation, national origin, ancestry, arrest record, conviction record; or membership in the national guard, state defense force, or any reserve component of the military forces of the United States or this state. The Plan agrees to maintain a written affirmative action plan, which shall be available upon request to the DEPARTMENT.

(3) The PLAN shall comply with all applicable requirements and provisions of the Americans with Disabilities Act (ADA) of 1990. Evidence of compliance with ADA shall be made available to the DEPARTMENT upon request.

(4) In cases where premium rate negotiations result in a rate that the BOARD'S actuary determines to be inadequately supported by data submitted by the PLAN, the BOARD may take any action up to and including limiting new enrollment into that PLAN.

2.3 CLERICAL AND ADMINISTRATIVE ERROR.

(1) Except for the constructive waiver provision of s. 3.6, no clerical error made by the employer, the DEPARTMENT or the PLAN shall invalidate CONTRACT BENEFITS of a PARTICIPANT otherwise validly in force, nor continue such BENEFITS otherwise validly terminated.

(2) Except for the constructive waiver provision of s. 3.6, if an EMPLOYEE or ANNUITANT has made written application during a prescribed enrollment period for either individual or family coverage and has authorized the PREMIUM contributions, CONTRACT BENEFITS shall not be invalidated solely because of the failure of the employer or the DEPARTMENT, due to clerical error, to give proper notice to the PLAN of such EMPLOYEE'S application.

(3) In the event that an employer erroneously continues to pay the PREMIUM for an EMPLOYEE who terminates employment, refunds of such premiums shall be limited to no more than two months of premiums paid.

(4) Except in cases of fraud, unreported death, misrepresentation, or when required by Medicare, retrospective adjustments to premium or claims for coverage not validly in force shall not be made prior to January 1 of the previous calendar year. In situations where coverage is validly in force, the employer has not paid premium, and the employee does not have a required contribution, retroactive premium will be made for the entire period of coverage, regardless of the discovery date.

(5) In the event that an employer determines an effective date under Wis. Stat. § 40.51 (7) based on information obtained from the DEPARTMENT available at the time the application is filed, such application shall

not be invalidated solely as a result of an administrative error in determining the proper effective date of employer contribution. No such error will result in providing coverage for which the employee would otherwise not be entitled.

2.4 REPORTING

(1) EMPLOYEES and ANNUITANTS shall become or be SUBSCRIBERS if they have filed with the employer or DEPARTMENT, if applicable, an application in the form prescribed by the DEPARTMENT, and are eligible in accordance with this contract, the law, the administrative rules, and regulations of the DEPARTMENT.

(2) On or before the effective date of this CONTRACT, the DEPARTMENT shall furnish a report to the PLAN showing the INDIVIDUAL SUBSCRIBERS and FAMILY SUBSCRIBERS entitled to BENEFITS under the CONTRACT during the first month that it is in effect, and such other reasonable data as may be necessary for PLAN administration. The DEPARTMENT shall furnish like reports for each succeeding month that the CONTRACT is in effect.

(3) Monthly or upon request by the DEPARTMENT, the PLAN shall submit a data file (or audit listing, if requested by the DEPARTMENT) to establish or update the DEPARTMENT'S membership files. The PLAN shall submit these files using the SUBSCRIBER identifiers (currently Social Security Number) determined by the DEPARTMENT. The PLAN shall create separate files for SUBSCRIBERS and DEPENDENTS, in a format specified by the DEPARTMENT (currently fixed length ASCII records), and submit them to the DEPARTMENT or its designated database administrator. The DEPARTMENT will submit to the PLAN error reports showing SUBSCRIBER and DEPENDENT records failing one or more edits to which the electronic updates are subjected, after which the PLAN shall correct and resubmit the failed records with its next monthly update.

(4) Unless individually waived by the BOARD, each PLAN will submit the current applicable version of the Health Plan Employer Data and Information Set (HEDIS) by June 1 for the previous calendar year. The data set will be for both the entire PLAN membership and the state group membership where applicable. The data will be supplied in a format specified by the DEPARTMENT.

(5) PLANS shall submit all reports and comply with all material requirements set forth in the GUIDELINES or the BOARD may terminate the contract between the PLAN and the BOARD at the end of the calendar year, restrict new enrollment into the PLAN, or impose other sanctions as deemed appropriate. These sanctions may include, but are not limited to, financial penalties for no more than $100 per day per occurrence, to begin on the 5th day following the date notice of non-compliance is delivered to the PLAN. Such financial penalty will not exceed $5000 per occurrence. The penalty may be waived if timely submission is prevented for due cause, as determined by the DEPARTMENT.

2.5 BROCHURES AND INFORMATIONAL MATERIAL

(1) The PLAN shall provide the SUBSCRIBER with identification cards and a listing of all available providers and available locations, and pre-authorization and referral requirements. If the PLAN is offering the 1993 level of benefits, it shall also provide the SUBSCRIBER with a brochure(s) explaining the PLAN BENEFITS, limitations, exclusions, maximum BENEFIT payments, deductibles and co-payments. The brochure shall be prepared in lay language for ease of understanding and it together with identification cards shall be provided to the SUBSCRIBER within 30 days of the EFFECTIVE DATE or the date the PLAN receives the SUBSCRIBER'S application, whichever is later. If the PLAN offers dental coverage, it must provide the PARTICIPANT a description of the dental network benefits, limitations and exclusions.

(2) All brochures and other informational material as defined by the DEPARTMENT must receive approval by the DEPARTMENT before being distributed by the PLAN. Five (5) copies of all informational materials in final form must be provided to the DEPARTMENT. At its discretion, the DEPARTMENT may designate a common vendor who shall provide the annual Description of Benefits and such other information or services it deems appropriate, including audit services. The vendor shall be reimbursed by the PLAN at cost, but not to exceed $.12 per member per month. PLANS will be advised of the amount of the charge prior to the due date for premium bids. The PLAN will be responsible for any costs assessed to the PLAN even if the PLAN is withdrawing from the program.

(3) Upon request, the PLAN will provide information on programs, services, and activities in alternate formats to PARTICIPANTS with qualified disabilities as defined by the Americans with Disabilities Act (ADA) of 1990. All brochures and informational material shall include the following statement:

> "[NAME OF PLAN] does not discriminate on the basis of disability in the provision of programs, services, or activities. If you need this printed material interpreted or in an alternative format, or need assistance in using any of our services, please contact [CONTACT PERSON OR OFFICE. INCLUDE PHONE NUMBER AND TTY NUMBER IF AVAILABLE]."

(4) If erroneous or misleading information is sent to SUBSCRIBERS by a provider or subcontractor, the DEPARTMENT may require a plan mailing to correctly inform PARTICIPANTS.

2.6 FINANCIAL ADMINISTRATION.

Prior to the beginning of any calendar month, the DEPARTMENT shall transmit to the PLAN that month's estimated PREMIUM for SUBSCRIBERS who are properly enrolled less the administration fees required by the BOARD.

2.7 INSOLVENCY (OR SOLVENCY).

(1) ATTACHMENT B provides documentation that, in the event the PLAN becomes insolvent or otherwise unable to meet the financial provisions of this CONTRACT, bonding or reinsurance exists to pay those obligations. Such bonding or reinsurance shall continue BENEFITS for all PARTICIPANTS at least until the end of the calendar month in which insolvency is declared. For a PARTICIPANT then confined as an INPATIENT, BENEFITS shall continue until the confinement ceases, the attending physician determines confinement is no longer medically necessary, the end of 12 months from the date of insolvency, or the CONTRACT maximum is reached, whichever occurs first. The DEPARTMENT will establish enrollment periods during which subscribers may transfer to another plan.

(2) The PLAN shall submit to the DEPARTMENT on an annual basis, information on its financial condition including a balance sheet, statement of operations, financial audit reports, and utilization statistics.

2.8 DUE DATES.

(1) Reports and remittances from employers required in the administration of the group health insurance program shall be submitted to the DEPARTMENT no later than the 20th day of the calendar month for the following month's coverage.

(2) The employer shall immediately forward to the PLAN the "carrier advance registration" copy of applications filed by newly eligible EMPLOYEES. The PLAN shall issue ID cards based upon the carrier advance registration copy of the application.

2.9 CONTINUATION OR CONVERSION OF INSURANCE.

(1) Except when coverage is canceled, PREMIUMS are not paid when due, coverage is terminated as permitted by state or federal law, or the employer is not notified of the participant's loss of eligibility as required by law, a PARTICIPANT who ceases to be eligible for BENEFITS may elect to continue group coverage for a maximum of 36 months from the date of the qualifying event or the date of the employer notice, whichever is later. Application must be received by the DEPARTMENT within 60 days of the date the PARTICIPANT is notified by the employer of the right to continue or 60 days from the date coverage ceases, whichever is later. The PLAN shall bill the continuing PARTICIPANT directly for required premiums. The PLAN may not apply a surcharge to the premium, even if otherwise permitted under State or federal law.

If the PARTICIPANT does not reside in a county listing a primary physician for the SUBSCRIBER'S PLAN at the time continuation coverage is elected, the PARTICIPANT may elect a participating plan in the county where the PARTICIPANT resides.

(2) Such PARTICIPANT may also elect to convert to individual coverage without underwriting if application is made directly to the PLAN within 30 days after termination of group coverage. The PARTICIPANT shall be eligible to apply for the direct pay conversion contract then being issued provided coverage is continuous and the premiums then in effect for the conversion contract are paid without lapse. The right to a conversion contract will also be offered when the PARTICIPANT reaches the maximum length of continuation of group coverage.

(3) Children born or adopted while the parent is continuing group coverage may also be covered for the remainder of the parent's period of continuation. A PARTICIPANT who has single coverage must elect family coverage within 60 days of the birth or adoption in order for the child to be covered. The PLAN will automatically treat the child as a qualified dependent, as required by COBRA and provide any required notice of COBRA rights.

2.10 GRIEVANCE PROCEDURE.

(1) Any dispute about health insurance benefits or claims arising under the terms and conditions of the agreement shall first be submitted for resolution through the PLAN'S internal grievance process and may then, if necessary, be submitted to the DEPARTMENT. The PARTICIPANT may file a complaint with the Manager of Quality Assurance for review. The PARTICIPANT may also request a departmental determination. The determination of the DEPARTMENT is final and not subject to further review unless a timely appeal of the determination by the DEPARTMENT is submitted to the BOARD, as provided by Wis. Stat. § 40.03 (6) (i) and Wis. Admin. Code § ETF 11.01 (3). The decision of the BOARD is reviewable only as provided in Wis. Stat. § 40.08 (12).

(2) The PARTICIPANT may also request an independent review § INS 18.11 Wis. Adm. Code. In this event, the DEPARTMENT must be notified by the PLAN of the PARTICIPANT'S request at the same time the Office of the Commissioner of Insurance is notified in a manner that is defined by the DEPARTMENT. In accordance with § INS 18.11 Wis. Adm. Code any determination by an Independent Review Organization is final and binding. PARTICIPANTS have review by the DEPARTMENT or BOARD once the Independent Review Organ

(3) The PLAN'S grievance procedure must be included as ATTACHMENT E. At a minimum, the grievance process must comply with Wis. Adm. Code § INS 18.3 or any other statutes or administrative codes

that relate to managed care grievances. This extends to any "carve-out" services (e.g., dental, chiropractic, mental health, prescription drug administrators).

(4) The PARTICIPANT must be provided with notice of the right to grieve and a minimum period of 60 days to file a grievance after written denial of a BENEFIT or occurrence of the cause of the grievance.

(5) Investigation and resolution of any grievance will be initiated within 5 days of the date the grievance is filed by the complainant in an effort to effect early resolution of the problem. Grievances related to an urgent health concern will be handled within four business days of the plan's receipt of the grievance.

(6) Notification of Determination Rights.

In the final grievance decision letters, the PLAN shall inform PARTICIPANTS of their right to request a DEPARTMENT review of the grievance committee's final decision. In the event they disagree with the final decision, PARTICIPANTS may submit a written request to the DEPARTMENT within 60 days OF THE FINAL GRIEVANCE DECISION LETTER. The DEPARTMENT will review, investigate, and attempt to resolve complaints on behalf of PARTICIPANTS. Upon completion of the DEPARTMENT review and in the event that PARTICIPANTS disagree with the outcome, PARTICIPANTS may file a written request for determination from the DEPARTMENT. The request must be received by the DEPARTMENT within 60 days of the date of the DEPARTMENT final review letter.

(7) Provision of Complaint Information.

All information and documentation pertinent to any decisions or actions taken regarding any participant complaint or grievance by a PLAN shall be made available to the DEPARTMENT upon request. Information may include complete copies of grievance files, medical records, consultant reports, customer service contact worksheets or any other documentation the DEPARTMENT deems necessary to review a PARTICIPANT complaint, resolving disputes or when formulating determinations. Such information must be provided within fifteen working days, or by an earlier date as requested by the DEPARTMENT.

(8) Notification of Legal Action.

If a PARTICIPANT files a lawsuit naming the PLAN as a defendant, the PLAN must notify the DEPARTMENT'S chief legal counsel within ten working days of notification of the legal action. This requirement does not extend to cases of subrogation.

(9) If a departmental determination overturns a PLAN'S decision on a PARTICIPANT'S grievance, the PLAN must comply with the determination within 90 days of the date of the determination or a $500 penalty will be assessed for each day in excess of 90 days. As used in this section, "comply" means to take action as directed in the departmental determination or to appeal the determination to the BOARD within 90 days.

ARTICLE 3 COVERAGE

3.1 EFFECTIVE DATE.

(1) The group health insurance program pursuant to Wis. Stats. § 40.51 (7), and under which the PLAN is participating according to the terms of this CONTRACT, shall be available beginning July 1, 1987. If recommended by the Department's actuary and approved by the Board, underwriting requirements may apply to municipalities joing the program.

(2) The governing body of an employer shall adopt a resolution for regular or deductible option coverage in a form prescribed by the DEPARTMENT. The effective date of coverage shall be the beginning of the calendar month on or after 90 days following receipt by the DEPARTMENT of the Resolution, unless the resolution specifies a later month and is approved by the DEPARTMENT. At least 30 days prior to the effective date, the DEPARTMENT must receive from the employer all EMPLOYEE and ANNUITANT applications for which coverage will begin on the effective date. If the number of EMPLOYEE applications received does not represent the minimum participation level as defined in Section 1, the resolution shall become void, unless the employer is granted a waiver of the participation requirement by the DEPARTMENT. Employees who are on a leave of absence and not insured under the employer's plan are eligible to enroll only under s. 3.10 if they returned to active employment. For ANNUITANTS and employees on leave of absence to be eligible under this section, they must be insured under the employer's current group health plan. Eligible EMPLOYEES who are not insured under the employer's current group health plan at the time the resolution to participate is filed or evidence of insurability is required, or those insured for single coverage who are enrolling for family coverage, shall be subject to the deferred coverage provisions of s. 3.10. This limitation will not apply to PARTICIPANTS insured under another group health insurance plan administered by the DEPARTMENT.

(3) Notwithstanding s. 3.2, any employer for whom the resolution made under 3.1 resulted in coverage effective January 1, 1988 or after shall be required to remain in the program for a minimum of 12 months and any employer who files a resolution after December 20, 1990, and who offers a non-participating plan pursuant to sub. (4) shall be required to remain in the program a minimum of three years.

(4) The employer may not offer group health insurance coverage to eligible EMPLOYEES from any health insurance carrier not participating in the health insurance program of the BOARD. However, the DEPARTMENT may allow any employer to offer a non-participating plan to a group of its employees if it can be demonstrated to the satisfaction of the DEPARTMENT that: (1) collective bargaining barriers require such other coverage; and (2) there will be no adverse impact to the program; and (3) that the minimum number of all of the employer's Wisconsin Retirement System participating employees, including those who are in the non-participating health plan, become insured under the program of the BOARD to meet the required participation levels as defined in Section 1. The Plan Stabilization Contribution may be increased for that employer if less than 50% of the participating EMPLOYEES elect the Standard Plan coverage.

(5) The employer may retain a second plan, as described in (4) above, or temporarily waive the participation requirements due to timing of collective bargaining, as described in (2) above, by executing the appropriate Resolution to Participate. The employer may later enroll the employees in the collective bargaining unit that did not enroll during the employer's initial enrollment period due to the employer retaining a second plan or due to the timing of collective bargaining. The employer must notify the Department, in writing, of this enrollment at least 30 days prior to the effective date of coverage for these employees. These employees may elect any available plan if they enroll with no lapse of coverage when their coverage under the other plan terminates.

(6) If participation by an employer is approved in accordance with Sub. (2) and the subsequent participation falls under the minimum requirement, the BOARD may terminate employer participation at the end of the calendar year by notifying the employer prior to October 1.

(7) The employer is responsible for notifying ANNUITANTS of the availability of coverage.

(8) The employer is responsible for notifying any SUBSCRIBERS covered under continuation of the prior group plan of the employer's change of coverage to or from this health insurance program. Notification and application should be sent to his/her last known address.

3.2 EMPLOYER TERMINATION.

(1) The governing body of an employer may terminate group health insurance under Wis. Stats. § 40.51 (7), for all PARTICIPANTS for whom rights to coverage were secured by the employer's participation by adopting a resolution in a form prescribed by the BOARD.

(2) A certified copy of the resolution in sub. (1) must be received in the DEPARTMENT by October 1 for termination to be effective at the end of the calendar year.

(3) If the employer fails to comply with (1) or (2) above, or if the employer fails to maintain the required participation level in the program, the DEPARTMENT may impose enrollment restrictions on the employer as it deems appropriate to preserve the integrity of the program. The DEPARTMENT may terminate the employer's participation in the program on the first of the month following notification to the employer that is has violated the terms of the contract. The DEPARTMENT may also restrict the employer's re-enrollment in the program beyond the restrictions set forth in item (4) below.

(4) Any employer who terminates participation under this section may not again elect participation earlier than 3 years after the date of termination. The employer is responsible for notifying annuitants and continuants of coverage termination.

3.3 SELECTION OF COVERAGE.

(1)(a) If coverage is not elected under this section, it shall be subject to the deferred coverage provision of section 3.10. Except as otherwise provided in this section, coverage shall be effective on the first day of the month which begins on or after the date the application is received by the employer.

(b) An EMPLOYEE shall be insured if coverage is selected as provided for in section 3.1 (2). If the EMPLOYEE is not eligible for employer contribution toward PREMIUM at that time, section 3.3 (3) applies.

(2)(a) An EMPLOYEE shall be insured if a completed DEPARTMENT application form is received by the employer within 30 days of hire, or before the effective date of the employer contribution toward the PREMIUM, to be effective the beginning of the month on or after the effective date of the date of employer contribution toward premium. An EMPLOYEE who enrolls for single coverage within 30 days of hire, may change to family coverage during the enrollment period offered as a result of becoming eligible for employer contribution toward premium. The EMPLOYEE and his or her DEPENDENTS shall not be subject to any waiting periods or evidence of insurability requirements.

(b) Notwithstanding paragraph (2) (a) above, an EMPLOYEE who is not insured but who is eligible for an employer contribution under ETF § 40.10 (2)(a), Wis. Adm. Code may elect coverage prior to becoming eligible for an employer contribution under ETF § 40.10 (2)(b), Wis. Adm. Code to be effective upon the date of the

(b) An employee who deferred coverage because he or she is covered under another plan may enroll for family coverage if he or she has a new dependent as a result of birth, adoption, placement for adoption or marriage, provided he or she submits an application within 60 days of that event.

(c) Coverage under this provision shall be effective on the date of termination of the prior plan or the date of the event as described in b. above. A full month's PREMIUM is due for that month if coverage is effective before the 16th of the month. Otherwise the entire premium for that month is waived.

(7) In the event a SUBSCRIBER files an application during a prescribed enrollment period listing a plan and a primary physician who is not available in the plan selected, the PLAN shall immediately reject the application and return it to the employer. The SUBSCRIBER shall be allowed to correct the plan selected to one which has that physician available, upon notice to the employer that the error occurred. The application shall be effective the later of first of the month following receipt of the application or the effective date of the original application. The PLAN shall also immediately reject the application and return it to the employer if the SUBSCRIBER fails to list a primary physician. The PLAN may not simply reassign a primary physician.

(8) An ANNUITANT shall be covered if a completed DEPARTMENT application form is received as specified in section 3.1 (2).

3.4 DUAL-CHOICE ENROLLMENT.

(1) The BOARD shall establish enrollment periods, which shall permit eligible and currently covered EMPLOYEES and ANNUITANTS to transfer coverage to any health care coverage plan offered by the BOARD pursuant to Wis. Stats. § 40.51 (7). Unless otherwise provided by the BOARD, the Dual-Choice enrollment period shall be held once annually in the fall of each year with coverage effective the following January 1.

(2) If a SUBSCRIBER has not received a Dual-Choice enrollment opportunity as determined by the DEPARTMENT, an enrollment opportunity may be offered prospectively.

(3) An EMPLOYEE who returns from leave of absence during which coverage lapsed and which encompassed the entire previous Dual-Choice enrollment period will be allowed a Dual-Choice enrollment provided an application is filed during the 30 day period which begins on the date the EMPLOYEE returns from leave of absence.

(4) An EMPLOYEE or ANNUITANT may also change plans if the SUBSCRIBER moves from his/her residence out of the plan's service area for a minimum of three months. A move from a medical facility to another facility by the subscriber is not considered a residential move. An application must be filed during the 30 day period which begins on the date the SUBSCRIBER moves.

(5) A subscriber under sections 3.4 (3) and (4) above who does not file an application to change plans within this 30-day enrollment period, may change only to the STANDARD PLAN, and shall be subject to the pre-existing condition clause contained in the STANDARD PLAN Contract. Coverage shall be effective the first day of the calendar month which begins on or after the date the application is received by the employer.

constructively waives coverage under section 3.6 or who subsequently cancels coverage elected under sections 3.3 or 3.4, may be insured only under the STANDARD PLAN, subject to any eligibility criteria and pre-existing condition clause contained in the STANDARD PLAN contract. Coverage shall be effective the first day of the calendar month, which begins on or after the date the application is received by the employer.

(2) An EMPLOYEE or ANNUITANT enrolled for individual coverage, though eligible for family coverage, and who subsequently elects family coverage after initial eligibility period specified in section 3.03 (3) shall be eligible for family coverage under the STANDARD PLAN. DEPENDENTS shall be subject to any pre-existing condition clause contained in the STANDARD PLAN contract.

(3) This section does not preclude an insured EMPLOYEE or ANNUITANT from changing to an alternate health care coverage plan during a dual-choice enrollment period offered under section 3.04.

3.11 COVERAGE OF SPOUSE.

If both spouses are annuitants or employed through the same employer and both are eligible for coverage, each may elect individual coverage. Two single contracts may be combined to one family contract, a family contract may be converted to two single contracts, or the family coverage may be changed from one spouse to the other without penalty effective the first day of the calendar month which begins on or after the date the employer receives the application. If, at the time of marriage, the spouses have coverage with different PLANS, they may elect family coverage with either PLAN. Should the spouses become divorced while carrying family coverage, the divorced spouse may elect coverage without lapse if the employer received the application within 30 days of the divorce. An employer may, at its option, allow both spouses to enroll for family coverage or one for single and one for family.

3.12 COVERAGE DURING AN UNPAID LEAVE OF ABSENCE.

(1) Any insured EMPLOYEE may continue coverage during any employer approved leave of absence or LAYOFF for up to 36 months. Insurance coverage may be continued beyond 36 months if the approved leave is a union service leave as provided for under Wis. Stats. §§ 40.02 (56) and 40.03 (6) (g). A return from a leave of absence under Wis. Stats. § 40.02 (40) is deemed to be the first day the EMPLOYEE returns to work if the EMPLOYEE resumes active performance of duty for 30 consecutive days for at least 50% of the EMPLOYEE'S normal work time. If the EMPLOYEE does not complete 30 days of duty, coverage as an active EMPLOYEE shall not be resumed.

(2) Except as provided in section 3.21, the insured EMPLOYEE is responsible for payment of the full PREMIUM which must be paid in advance, and each payment must be received by the employer at least 30 days prior to the end of the coverage period for which PREMIUMS had previously been paid.

(3) Any insured EMPLOYEE for whom coverage lapses or who allows family coverage to lapse during the leave of absence but continues individual coverage as a result of non-payment of premium may reinstate coverage by filing an application with the employer within 30 days of the return from leave. Coverage is effective the 1st day of the month on or after the date the employer receives the application. If such an EMPLOYEE was on a leave under the Family Medical Leave Act (FMLA) coverage is effective upon the date of re-employment in accordance with federal law. A full month's PREMIUM is due for that month if coverage is effective before the 16th of that month. Otherwise, the entire PREMIUM for that month is waived.

(2) Coverage for a person otherwise eligible who is entitled to:

(a) and applies for an immediate annuity under Wis Stat. § 40.02 (38), may be reinstated even if during any period preceding retirement, insurance has not been in effect while no earnings were received, or insurance has been continued under COBRA continuation through the State's health insurance program. An application for health insurance must be received by the DEPARTMENT within 30 days after the date of the DEPARTMENT'S benefit approval notice. Coverage shall be effective the first day of the calendar month which occurs on or after the date the application for health insurance has been received.

(b) and applies for an LTDI benefit under Wis. Admin. Code § ETF 50.40, or a duty disability benefit under Wis. Stat. § 40.65, may be reinstated even if, during the period proceeding the benefit approval, no insurance was in effect while no earnings were received, or insurance has been continued under COBRA continuation through the State's health insurance program. An application for health insurance must be received by the DEPARTMENT within 30 days after the date of the DEPARTMENT'S benefit approval notice. Coverage shall be effective the first day of the calendar month which occurs on or after the date the application for health insurance has been received.

(3) The DEPARTMENT may authorize PREMIUM payments to be made directly to the PLAN where circumstances require such. Failure to make required PREMIUM payments by the due dates established by the PLAN and approved by the DEPARTMENT shall cause the health care coverage to be irrevocably canceled.

3.16 COVERAGE OF ANNUITANTS AND SURVIVING DEPENDENTS ELIGIBLE FOR MEDICARE.

(1) Each insured ANNUITANT, their DEPENDENTS or surviving DEPENDENTS who becomes insured under federal plans for hospital and medical care for the aged (Medicare) may continue to be insured, but at reduced PREMIUM rates as specified by the BOARD.

(2) The reduction in PREMIUM shall be effective on the first day of the calendar month, which begins on or after the date the Medicare hospital, and medical insurance benefits (Parts A and B) become effective.

(3) Except in cases of fraud which shall be subject to section 3.18(5), coverage for any person who does not enroll for the voluntary medical insurance portion of the federal program when it is first available as the primary carrier shall be limited in accordance with Uniform Benefits IV., A., 12., b.

(4) Enrollment under the federal plans for hospital and medical care for the aged (Medicare) by EMPLOYEES and ANNUITANTS who are eligible for those programs is waived if the EMPLOYEE remains covered as an active employee of the participating employer. Enrollment in Medicare Part B is required for the EMPLOYEE or DEPENDENTS at the first Medicare enrollment period after active employment ceases. If an ANNUITANT or an ANNUITANT'S spouse is covered under an active employee's group health insurance policy with another employer and that policy is the primary payor, the ANNUITANT or the ANNUITANT'S spouse covered under that policy may also defer enrollment in Medicare Part B (to the extent allowed by federal law) under this provision and shall pay the Medicare rates for coverage under this program.

(5) Enrollment under the federal plans for hospital care for the aged (Medicare) by EMPLOYEES, ANNUITANTS and their dependents who are eligible for those programs is waived if the insured EMPLOYEE, ANNUITANT, or DEPENDENT is required to pay a premium to enroll in the hospital portion of Medicare (Part A). However, if Part A is not elected, the reduced premium rate is not available.

(6) If a Medicare coordinated family premium category has been established for a family, and one or more family members enrolled in both parts of Medicare dies, the family premium category in effect shall not change solely as a result of the death.

(7) If the EMPLOYEE, ANNUITANT, or DEPENDENT is eligible for Medicare due to permanent kidney failure or end-stage renal disease, this PLAN shall pay as the primary payor for the first thirty months after he or she became eligible for Medicare due to the kidney disease, whether or not the EMPLOYEE, ANNUITANT, or DEPENDENT is enrolled in Medicare. The premium rate will be the non-Medicare rate during this period. Medicare becomes the primary payor after this thirty-month period. If the EMPLOYEE, ANNUITANT, or DEPENDENT has more than one period of Medicare enrollment based on kidney disease, there is a separate thirty-month period during which this PLAN will again be the primary payor. No reduction in premium is available for active employees under this section.

3.17 CONTRACT TERMINATION.

(1) The contract terminates on the date specified on the signatory page. The BOARD, by September 1, or the PLAN, by August 15, shall provide notice of its intent not to contract for the following year by providing notice to the other party. The PLAN must provide written notification to its SUBCRIBERS that it will not be offered during the next calendar year. This notification must be sent prior to the dual-choice enrollment period.

(2) If the PLAN terminates this CONTRACT pursuant to sub. (1), any PARTICIPANT who is receiving BENEFITS as an INPATIENT on the date of termination shall continue to receive all BENEFITS otherwise available to INPATIENTS until the earliest of the following dates:

(a) The CONTRACT maximum is reached.

(b) The attending physician determines that confinement is no longer medically necessary.

(c) The end of 12 months after the date of termination.

(d) Confinement ceases.

(3) If the PLAN ceases to be offered after a PARTICIPANT has fully satisfied a deductible, which is required initially, but not in subsequent time periods, but prior to the completion of the treatment program, liability for such services remains the responsibility of the PLAN without requiring further PREMIUM payments. However, an acceptable alternative would be for the PLAN to refund the deductible amount to the SUBSCRIBER.

(4) If the BOARD terminates this CONTRACT pursuant to sub. (1), then all rights to BENEFITS shall cease as of the date of termination. The PLAN will cooperate with the BOARD in attempting to make equitable arrangements for continuing care of PARTICIPANTS who are INPATIENTS on the termination date. Such arrangements may include but are not limited to: transferring the patient to another institution; billing the BOARD a fee for service rendered; or permitting non-plan physicians to assume responsibility for rendering care. The overall intent is to be in the best interest of the patient.

(5) If the PLAN terminates this CONTRACT, the PLAN shall not again be considered for participation in the program under Wis. Stats. § 40.03 (6) (a) for a period of three contract years.

3.18 INDIVIDUAL TERMINATION OF COVERAGE

(1) A PARTICIPANT'S coverage shall terminate on the earliest of the following dates:

(a) The effective date of change to another health care plan through the BOARD approved enrollment process.

(b) The expiration of the period for which PREMIUMS are paid when PREMIUMS are not paid when due. Pursuant to Federal law, if timely payment is made in an amount that is not significantly less than amount due, that amount is deemed to satisfy the PLAN'S requirement for the amount that must be paid. However, the PLAN may notify the PARTICIPANT of the amount of the deficiency and grant a reasonable time period for payment of that amount. Thirty days after the notice is given is considered a reasonable time period.

(c) The expiration of the 36 months for which the SUBSCRIBER is allowed to continue coverage while on a leave of absence or LAYOFF, as provided in section 3.12.

(d) The end of the month in which a notice of cancellation of coverage is received by the EMPLOYER or by the DEPARTMENT in the case of an ANNUITANT for whom the employer has no reporting responsibilities.

(e) The definition of PARTICIPANT no longer applies (such as a dependent child's marriage, divorced spouse, etc.). If family coverage remains in effect and the employee fails to notify the employer of divorce, coverage for the ex-spouse ends the last day of the month in which notification occurs. The employer may collect premium retroactively from the subscriber if the divorce was not reported in a timely manner and there were no other eligible dependents for family coverage to remain in effect.

(f) The expiration of the 36 months for which the PARTICIPANT is allowed to continue under paragraph (4), as required by state and federal law.

(g) The effective date of coverage obtained with another employer group health plan which coverage does not contain any exclusion or limitation with respect to any preexisting condition of participant who continues under section 3.18 (4) of this section.

(h) The earliest date Federal or State continuation provisions permit termination of coverage for any reason, except the BOARD specifically allows the employee to maintain coverage for 36 months instead of 18.

(i) The first day of the month following the DEPARTMENT'S written notice to an employee who is ineligible for coverage but, due to employer or DEPARTMENT error, was enrolled for coverage as an EMPLOYEE. The employee (and any eligible dependents) will be offered a special continuation period of 36 months. The continuation period will be administered in accordance with paragraph (4).

(2) No refund of any PREMIUM under sub. (e) may be made unless the employer, or DEPARTMENT if applicable, receives a written request from the SUBSCRIBER by the last day of the month preceding the month for which PREMIUM has been collected or deducted.

(3) Except when a PARTICIPANT'S coverage terminates because of cancellation or non-payment of PREMIUM, BENEFITS shall continue to the PARTICIPANT if confined as an INPATIENT, but only until the attending physician determines that confinement is no longer medically necessary, the CONTRACT maximum is reached, the end of 12 months after the date of termination, or confinement ceases, whichever occurs first.

(4) A PARTICIPANT who ceases to meet the definition of EMPLOYEE/ANNUITANT/ DEPENDENT may elect to continue group coverage for a maximum of 36 months. Application must be postmarked within 60 days of the date the PARTICIPANT is notified of the right to continue or 60 days from the date coverage

3.21 EMPLOYER CONTRIBUTIONS TOWARD PREMIUM.

(1) The employer contribution toward PREMIUM for any EMPLOYEE shall be at least 50% but no more than 105% of the gross PREMIUM of the least costly health care coverage plan approved by the BOARD which is in the service area of the employer. The DEPARTMENT shall determine the service area of the employer. The effective date of the employer contribution shall not be later than the first of the month after which the EMPLOYEE completes 6 months service with the employer under the Wisconsin Retirement System.

(2) Notwithstanding sub. (1), the amount of employer contribution toward PREMIUM for ANNUITANTS, EMPLOYEES on approved leave of absence or LAYOFF, or those whose coverage is continued under 2.09 (1) shall be at the discretion of the employer.

(3) The minimum contribution for an EMPLOYEE who is appointed to work less than 1,044 hours per year shall be 25% of the lowest cost plan.

(4) If the amount of employer contribution changes, a new dual-choice offering may be made to its EMPLOYEES as determined by the DEPARTMENT.

(5) ANNUITANTS for whom the employer contributes toward the PREMIUM shall be treated as EMPLOYEES for the purpose of PREMIUM and coverage reporting.